

**MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM  
APPLICATION FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL (CAH)**

**Applicant:**

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(Name of Facility)

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(Address)

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(City, State, Zip Code)

**A. Please check the appropriate statements and complete required sections**

**Criterion 1: Eligibility**

The applicant:

\_\_\_\_\_ Is a nonprofit, for-profit or public hospital.

\_\_\_\_\_ Is located outside a Metropolitan Statistical Area (Office of Management and Budget), not in an urban area, and not classified as an urban hospital for purposes of the standardized payment amount (HCFA or Medicare Geographic Classification Review Board).

**Criterion 2: Road miles to next closest hospital/necessary provider**

The applicant:

\_\_\_\_\_ Is located more than a 35-mile drive by primary highway from a hospital or CAH; or

\_\_\_\_\_ Is located more than a 15-mile drive from a hospital or CAH in mountainous terrain or in areas with only secondary roads available (a secondary road is defined as any road that is not a paved Interstate, U.S., or state highway); or

\_\_\_\_\_ Meets one of the following criteria to be certified by the State as a necessary provider of health care services to residents in the area:

\_\_\_\_\_ Is located in a Health Professional Shortage Area (HPSA); or

\_\_\_\_\_ Combined acute inpatient days for Medicare and Medicaid beneficiaries account for at least 50% of the hospital's total acute inpatient days in the last full year for which data is available.

\_\_\_\_\_ Total Inpatient Days

\_\_\_\_\_ Number of Medicare Inpatient Days

\_\_\_\_\_ Number of Medicaid Inpatient Days

\_\_\_\_\_ Data Period (Month, Year to Month, Year)

**Criterion 3: Member of a rural health network**

If the applicant is a member of a rural health network, the applicant:

\_\_\_\_\_ Has agreements with at least one referral hospital for: (1) patient referral and transfer; (2) the development and use of communications systems, including telemetry systems and systems for electronic sharing of patient data (if the network has such a system in operation); and (3) the provision of emergency and non-emergency transportation.

The following referral hospital(s) has sufficient resources and a demonstrated history of accepting patient referrals/transfers from the applicant:

Referral Hospital: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Other Referral Hospital  
(if more than one): \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Criterion 4: Credentialing and quality assurance**

\_\_\_\_\_ Has agreements with respect to credentialing and quality assurance with at least: (1) one hospital that is a member of the network, (2) a peer review organization, or (3) another appropriate and qualified entity identified in the state rural health care plan, e.g., Department of Health and Welfare.

**Criterion 5: Emergency services**

The applicant:

\_\_\_\_\_ Makes available 24-hour emergency care services, seven days a week and has a practitioner (doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner) with training or experience in emergency care on-call and available immediately by telephone or radio contact and available on-site within 30 minutes on a 24-hour per day basis.

\_\_\_\_\_ Has a plan for coordination with the emergency response system of the area.

**Criterion 6: Bed size**

The applicant:

\_\_\_\_\_ Utilizes acute and swing beds, of which the combined total of patient occupied beds does not exceed 25 at any time.

**Criterion 7: Staffing**

The applicant:

\_\_\_\_\_ Agrees to maintain staffing levels of at least one registered nurse available on call on a 24-hour basis.

\_\_\_\_\_ Agrees to maintain a registered nurse on-site at all times if the facility has at least one acute care patient.

**Criterion 8: Acute care inpatient length of stay**

The applicant:

\_\_\_\_\_ Agrees to have a written policy in effect to limit inpatient lengths of stay to an average of 96 hours facility wide.

**B. Supporting Documentation**

Please complete the following pertaining to the applicant.

\_\_\_\_\_ Approximate number of referrals/transfers from the applicant to the referral hospital in the last year.

\_\_\_\_\_ Number of licensed beds to be used for acute care only (CAH)

\_\_\_\_\_ Number of licensed beds to be used for swing bed care (CAH)

\_\_\_\_\_ Total number of licensed beds to be used for either acute or extended care

Do you plan to de-license beds to meet bed size criteria under CAH?

\_\_\_\_\_ Yes    \_\_\_\_\_ No

If yes, how many beds do you plan to de-license? \_\_\_\_\_

Although assessments of the following activities are strongly suggested prior to conversion to a CAH, completion of the table is optional.

Activity	Completion Date	Planned	Not Planned
Financial feasibility study for CAH			
Medical Staff Planning/Education			
Hospital Board Planning/Education			
Community Planning/Education			

\_\_\_\_\_  
Administrator

Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone \_\_\_\_\_

Fax Number \_\_\_\_\_

**RETURN BY FAX TO:**

**208/332-7262**

ATTN: Mary Sheridan, Director  
State Office of Rural Health  
Idaho Department of Health and Welfare

**208/338-7800**

ATTN: Bonnie Haines, Senior Vice President  
Idaho Hospital Association